

March 24, 2003

Re: Medical Dispute Resolution
MDR #: M2-03-0541-01-SS
IRO Certificate No.: IRO 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ____ for an independent review. ____ has performed an independent review of the medical records to determine medical necessity. In performing this review, ____ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Orthopedic/Spine Surgery.

Clinical History:

This 51-year-old male claimant suffered an on-the-job injury on _____. An MRI in September 2002 revealed a 2-3 mm posterior central discal substance herniation that contacts and indents the anterior thecal sac contours. He has undergone extensive conservative treatment for low back pain with lumbar radiculopathy and was referred for consideration for percutaneous discectomy at L5-S1.

Disputed Services:

Percutaneous discectomy at L5-S1.

Decision:

The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that the a percutaneous discectomy at L5-S1 is not medically necessary in this case.

Rationale for Decision:

Percutaneous lumbar discectomy is an unproven technique. There are no published randomized trials demonstrating efficacy over no treatment, or over conservative treatment. There is also no good single-arm prospective study with pre- and post-procedure validated outcome studies with reasonable follow-up showing that it has any efficacy at all over doing nothing.

At this point, no good literature exists supporting this procedure. Given that the basic science is generally not well thought of, the

reviewer does not think this procedure is supported by any reasonable standard of care either in spine surgery, or in the more conservative specialties that participate in spinal care.

I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ____ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO March 24, 2003.

Sincerely,